

PLEASE
DO NOT
STAPLE
IN THIS
AREA

°Private Provider
°Immunizations Only

HEALTH INSURANCE CLAIM FORM																																																																																																																																																																																									
1. MEDICARE MEDICAID CHAMPUS CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) <input checked="" type="checkbox"/> (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) 9000000007																																																																																																																																																																																				
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Barkley, Charles					3. PATIENT'S BIRTH DATE MM DD YY SEX 09 06 2002 M X F																																																																																																																																																																																				
5. PATIENT'S ADDRESS (No., Street) 22 Basketball Blvd. CITY Raleigh STATE NC ZIP CODE 27600 TELEPHONE (Include Area Code) (919) 555-1212					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/> 8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Student <input type="checkbox"/>																																																																																																																																																																																				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) a. OTHER INSURED'S POLICY OR GROUP NUMBER b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F c. EMPLOYER'S NAME OR SCHOOL NAME d. INSURANCE PLAN NAME OR PROGRAM NAME					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? PLACE (State) YES <input type="checkbox"/> NO <input type="checkbox"/> c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE																																																																																																																																																																																				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____					11. INSURED'S POLICY GROUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY SEX M F b. EMPLOYER'S NAME OR SCHOOL NAME c. INSURANCE PLAN NAME OR PROGRAM NAME d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																																																																																																																																																																				
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY					15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY																																																																																																																																																																																				
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE					17a. I.D. NUMBER OF REFERRING PHYSICIAN																																																																																																																																																																																				
19. RESERVED FOR LOCAL USE					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																																																																																																																																																																				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE) 1. L V06 . 1					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																																																																																																																																				
<table border="1"> <thead> <tr> <th colspan="2">24. A</th> <th colspan="2">B</th> <th colspan="2">C</th> <th colspan="2">D</th> <th colspan="2">E</th> <th colspan="2">F</th> <th colspan="2">G</th> <th colspan="2">H</th> <th colspan="2">I</th> <th colspan="2">J</th> <th colspan="2">K</th> </tr> <tr> <th colspan="2">DATE(S) OF SERVICE</th> <th colspan="2">Place of Service</th> <th colspan="2">Type of Service</th> <th colspan="2">PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER</th> <th colspan="2">DIAGNOSIS CODE</th> <th colspan="2">\$ CHARGES</th> <th colspan="2">DAYS OR UNITS</th> <th colspan="2">EPSDT Family Plan</th> <th colspan="2">EMG</th> <th colspan="2">COB</th> <th colspan="2">RESERVED FOR LOCAL USE</th> </tr> </thead> <tbody> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90471</td><td>EP</td><td></td><td>13</td><td>71</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90472</td><td>EP</td><td></td><td>13</td><td>71</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90700</td><td></td><td></td><td>0</td><td>00</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90713</td><td></td><td></td><td>0</td><td>00</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90744</td><td></td><td></td><td>0</td><td>00</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>11</td><td>22</td><td>02</td><td>11</td><td>22</td><td>02</td><td>11</td><td>90647</td><td></td><td></td><td>0</td><td>00</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>										24. A		B		C		D		E		F		G		H		I		J		K		DATE(S) OF SERVICE		Place of Service		Type of Service		PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		DIAGNOSIS CODE		\$ CHARGES		DAYS OR UNITS		EPSDT Family Plan		EMG		COB		RESERVED FOR LOCAL USE		11	22	02	11	22	02	11	90471	EP		13	71	1										11	22	02	11	22	02	11	90472	EP		13	71	1										11	22	02	11	22	02	11	90700			0	00	1										11	22	02	11	22	02	11	90713			0	00	1										11	22	02	11	22	02	11	90744			0	00	1										11	22	02	11	22	02	11	90647			0	00	1									
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25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For gov. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>					28. TOTAL CHARGE \$ 27 42					29. AMOUNT PAID \$					30. BALANCE DUE \$ 27 42																																																																																																																																																																
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signature on File SIGNED _____ DATE 11/24/02					32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)					33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Strickland Pediatrics 21 Fortune Drive Raleigh, NC 27600 PIN# 8900000 GRP# 8901000																																																																																																																																																																															

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

 APPROVED OMB-0938-0008 FORM CMS-1500 (12-90) FORM RRB-1500,
 APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)